3-2-2000

A Direct Practice Evaluation on the Effectiveness of Using a Strength-Based Approach with Children Living in Foster Care

Emily E. Vincent
Augsburg College

A DIRECT PRACTICE EVALUATION ON THE EFFECTIVENESS OF USING A STRENGTH-BASED APPROACH WITH CHILDREN LIVING IN FOSTER CARE

BY

EMILY E. VINCENT

A THESIS

SUBMITTED TO THE FACULTY OF THE GRADUATE PROGRAM

IN PARTIAL FULFILLMENT OF THE REQUIREMENTS

FOR THE MASTER'S DEGREE IN SOCIAL WORK

AUGSBURG COLLEGE

MINNEAPOLIS, MINNESOTA

MARCH 2, 2000

MASTER OF SOCIAL WORK
AUGSBURG COLLEGE
MINNEAPOLIS, MINNESOTA

CERTIFICATE OF APPROVAL

This is to certify that the Master's Thesis of

EMILY E. VINCENT

Has been approved by the Examining Committee for the thesis requirements for the master of Social Work Degree.

Date of Oral Presentation: March 2, 2000

Thesis Committee:

Laura Boisen

Thesis Advisor - Laura Boisen

Thesis Reader – Michael Schock

Diane McGowan

Thesis Reader – Diane McGowan

ABSTRACT

A DIRECT PRACTICE EVALUATION ON THE EFFECTIVENESS OF USING A STRENGTHS BASED APPROACH WITH CHILDREN LIVING IN FOSTER CARE

Emily E. Vincent

March 2, 2000

This mixed method qualitative / quantitative direct practice evaluation was undertaken to evaluate the effectiveness of working from a strength-based versus a problem-based approach with children living in foster care. A strength-based approach focuses on a client's positive qualities and identifies the skills they possess that will help them to overcome their situation. The purpose for this approach is to build on and encourage, through a strength-based practice, the certain individual attributes of the child and family and community supports that can enhance resiliency in children.

Three boys living in foster care ages 8-11 were evaluated three times over a six month period. The boys evaluated themselves using the Piers-Harris Self Concept Scale (PHSCS) and their foster mothers evaluated them as well using the Behavioral Emotional Rating Scale (BERS).

The results indicate that no significant changes were found. In order to find any potential significant changes, evaluation would need to continue for a longer period of time. However through the strength-based case management intervention, some of the protective factors within the three boys individual, familial, and community systems were increased. Suggestions are made for continuing to evaluate the effectiveness of a

strength-based approach in order to advance the scientific basis of strength-based interventions.

TABLE OF CONTENTS

TABLES

Chapter One

Introduction

Overview

I conducted a direct practice evaluation of my work as case manager with three foster children associated with the therapeutic foster care agency, Family Alternatives. I evaluated the effectiveness of working from a strength-based approach, which is an alternative to the "problem-centered" traditional social work model. The problem centered model for assessing and evaluating foster children focuses on the identified problem(s) of the child to develop the goals and objectives of treatment. A strength-based approach focuses on a client's positive qualities and identifies the skills they possess that will help them to overcome their situation. It also encourages social workers to view clients as whole, not broken, people who do not need to be "fixed". The purpose of this approach is to build on and encourage certain individual attributes of the child, family and community supports that can enhance adaptation and health in children.

Introduction

Saleeby (1992) states that social work practice should be "guided first and foremost by a profound awareness of, and respect for, clients' positive attributes and abilities, talents and resources, desires and aspirations" (p.6). Weick, Rapp, Sullivan, and Kisthardt (1989) state that "a strengths perspective rests on the appreciation of the positive attributes and capabilities that people express and on ways in which individual and social resources can be developed and sustained" (p. 352).

Currently, a radical shift is occurring at Family Alternatives in which children are being viewed as having the capacity to adapt and to be competent, contributing members of

their community. The focus in assessment, evaluation and programming is being removed from one which is squarely on the child's problems, to a focus which recognizes the child's strengths, assets, and goals as the core from which all positive development springs. This type of approach works within a strengths based model, which will be described in the review of literature.

This literature review will also explore the replacement of "at-risk" language with language, which reflects the view of children "at promise" when using a strength-based model. Foster children are often viewed as "at-risk" which is a deficit-focused term. Authors Carlson and Smith (1997) define risk factors as "those circumstances that increase the likelihood that a child will develop an emotional or behavioral disorder compared with children from the general population"(p.234). Risk factors can include individual and family characteristics, or the interactions between people and their environments, (i.e. ethnic minority status, poverty, parental discord, and mental illness). The authors state that risk factors have the potential to threaten child and adolescent well being and make the individual, family, or community vulnerable to adverse outcomes.

Chapter Two

Literature Review

Overview

The second chapter contains two sections, the literature review and the theoretical and conceptual framework. The literature identifies the benefits of using a strength based approach in social work, which focuses on the strengths and positive qualities of individuals, rather than focusing on an individual's problems or deficits. The literature explains the problems of using an at-risk or problem focus on clients and identifies how the strength-based model can promote growth and well-being in individuals. The theoretical framework discusses the use of systems theory when working with clients from a strength based approach.

Social work's history of deficit vs. strength-based work

Weick et al. (1989) state that although the social work profession "has not been oblivious to the importance of recognizing individual strengths in practice encounters...social work's origins are in the concept of moral deficiency" (p.350). Two parallel movements during the progressive era that illustrated the difference between strength-based versus deficit-focused work were the Settlement House Movement and the Charity Organization Society. The Settlement House Movement in the 1930's seemed to operate from an appreciation of the influence of the social environment on individual functioning. Jane Addams and Mary Richmond, two early leaders of the social work profession, were concerned about the impact of the social environment on individuals and their families. Saleeby (1992) writes that Mary Richmond "focused on problems of the adjustment of the individual to the changing and sometimes pernicious social order"(p. 150). Jane Addams considered the Settlement House Movement as "an experiemental

effort to aid in the solution of the social and industrial problems, which are engendered by the modern conditions of life in a great city"(Saleeby, 1992, p.150). The authors Weick et al. (1989) also refer to The Charity Organization Society (COS) in the late 1800's in which the people believed that poverty was attributed to a lack of moral will and work ethic and was an example of the conceptual thread in social work that poverty and peoples' problems can be solved through the reinforcement of a stronger work ethic and moral conversion. The COS response to poverty was not through financial assistance but through moral persuasion and influence.

An increasing interest in the use of psychoanalytic theory to define people's problems in the 1930's also made a more "sophisticated connection with human weaknesses as the critical variable in understanding human problems" (Weick, et al, 1989, p.350). Saleeby (1992) stated that "in the 1930s, '40s, and 50s, the primary causal force hypothesized in the development of mental illness moved from social disorganization to hidden pathological urges, deficits, and dynamic tensions located in the conscious and unconscious dimensions of the personality of the individual"(p.151). With the birth of clinical diagnosis and a language of pathology, professionals began to categorize their clients in terms of their diagnostic label, which were established according to individual behavior. While the social work profession has not been unmindful of the value of appreciating client's strengths, Weick et al. (1989) wrote that there still remains "a subtle and elusive focus on individual or environmental deficits" (p.350). The deficit, problem-focused model of helping, has permeated the fields of medicine, public health, child welfare, social work, and education. It is a model in the helping professions that focus on the lack of abilities and skills and dysfunctional behavior of people, typically reinforcing negative qualities and attributes. Epstein, and Sharma (1998) state that "the deficit approach has a rich

history of development, well-articulated assumptions about human functioning and empirical support" (p.3).

Cowger (1994) wrote that "much of the social work literature on practice with families continues to use treatment, dysfunction and therapy metaphors and ignores work on family strengths ... The assessment literature, including available assessment instruments, is overwhelmingly concerned with individual inadequacies" (p.262). This type of approach creates a loss of hope and motivation in people and is often ineffective in moving clients beyond their situation and overcoming it.

Problems of deficit-focused work

Many problems are rooted in deficit-focused work. Weick et al. (1989) identified three: "1) the problem invariably is seen as a lack or inability in the person affected, 2) the nature, of the problem is defined by the professional, and 3) treatment is directed toward overcoming the deficiency at the heart of the problem"(p.352). The first of these problems does not recognize the thinking that individuals exist in different levels of systems and that these systems all affect one another. Deficit-focused work stems from an individualistic explanation for problems and does not consider the constant interaction between individuals and their environment and how those interactions affect both.

The second problem is an issue of power. When the professional and not the client defines a problem, it is assumed that the professional, not the client, knows best how they should lead their life. This power and authority that the worker is assumed to have over client's lives and situation creates dependency and helplessness in the client and guarantees that the helping encounter will be a never-ending process. The hope to empower clients is lost as they passively participate in therapy, looking to the professional for answers on how to heal.

The third problem concerns the goals established through a deficit approach. Many of the goals in this type of model are centered on the problem, which becomes the main point of intervention. Treatment is focused on alleviating the symptoms of the individual's behavior and problems. Allowing problem definition to become the goal of treatment hinders the growth and development of the client. Weick et al. (1989) argue that "this triumvirate helps ensure that the helping encounter remains an emergency room, where wounded people come to be patched up"(p.352).

Whereas traditional social work has focused on identifying the problem and centering the client's goals around it, the strengths perspective places attention on the capabilities and strengths of the client and explores the possibilities of healing through the client's positive, rather than negative, attributes. Working from a deficit-focused model presupposes that the professional holds all knowledge and power. Professionals working within a strengths-based model pursue a more collaborative effort with the client in understanding the client's situation and defining and creating their goals (Berg & DeJong, 1996). In this way, the client who will define their own objectives through the recognition of the strengths and abilities they possess determine the helping process. Berg and DeJong (1996) state that working from this perspective involves collaborating with clients "to explore and define two matters: 1) what it is they want different in their lives and 2) what strengths and resources they can bring to bear on making these desired differences a reality" (p.377).

When viewing people and their environment with a strengths perspective lens, the opportunity for hope and possibility broadens. Dennis Saleeby (1997) states that,

"Practicing from a strengths perspective demands a different way of seeing clients, their environments, and their current situation. Rather than focusing on problems, your eyes turn

towards possibility. In the thicket of trauma, pain, and trouble, you can see blooms of hope and transformation"(p. 4).

Strengths-based model

An alternative for approaching and working with clients is a strengths-based model, which focuses on a client's positive qualities and identifies the skills they possess which will help them overcome their situation. Weick et al (1989) re-introduced the idea of a strengths perspective to the field of social work in 1989. This perspective rejects the idea that there is an absolute truth to be discovered about people or the challenges they face, but instead, encourages people to work toward establishing their own meanings by focusing on their strengths and resources. Social workers who work within a strengths-based model encourage people to construct meanings that are useful for working toward their goals. Each client is seen to be the expert of his or her own situation. Nichols et al. (1998) state that the practitioner's knowledge, experience, and values are no more true or final than the client's. According to Weick (1992), "This stance is opposed to the scientific model of knowledge, which rests on the assumption, among others, that reality can be measured, tested, and objectively verified" (p.21).

Systems Theory

The strengths perspective is also strongly rooted in the general systems theory which focuses on 'wholes' and explores how different levels of systems affect each other by information being passed through the boundaries of these systems. Malcolm Payne (1997) wrote that the general systems theory "is a biological theory which proposes that all organisms are systems, composed of subsystems, and are in turn, part of super-systems" (p.137). Ashford, Lecroy, and Lortis (1997) describe four levels of systems that are useful to social workers when working within a general systems theory perspective: microsystems, mesosystems, exosystems, and the

macrosystem. Microsystems are those that involve direct contact between individuals within that system, i.e. family. Mesosystems are those settings in which we live our social lives, i.e. school, work. Exosystems are societies larger social institution's, such as local government, which affect our personal systems. The fourth and largest system we exist in and are a part of is the macrosystem which, according to Ashford et al. (1997) "has the most pervasive level of influence on social activities" (p.85). This system refers to the larger cultural contexts in which the microsystem, mesosystem, and exosystem exist.

In my work with children living in foster care, the systems theory provides a way of understanding how these children and their situations are affected through the many different systems of which they are a part. Payne (1997) stated that with a systems theory perspective, social workers try to locate which part of the interaction between clients and their environment are causing the problems. A few of the tasks of a social worker working within a systems perspective is to create an environment of shared power such that the client will be able to empower themselves and use their own abilities in problem solving, connect people to resource systems and help to construct healthy interactions between people and resource systems.

Social workers using and practicing from a general systems theory do not limit themselves to a sole focus on an individual or their environment, but instead broaden their focus to the interactions between the individual and their environment. Payne (1997) states that the strengths-perspective "focuses on people's own ability to define their interaction with the environment"(p.273). The strengths perspective is understood as a way of seeing-people and their environment, not in terms of their pathologies or problems, but rather as individuals and communities with strengths, abilities, and skills. "Neither the client nor the environment is necessarily seen as having problems. The interaction between them may be the difficulty" (Payne,

1997). By focusing on the positive qualities and strengths of a client, they are empowered with the knowledge that they themselves possess the tools to positively reconstruct their situation and can begin working toward health and healing. Saleeby (1996) defines empowerment as "assisting individuals, families, and communities in discovering and using the resources and tools within and around them" (p.298). Cowger wrote that the role of the social worker is not to empower people and that power is not something that social workers possess that they can distribute to clients at will. Simon (1990) adds to the definition of empowerment by stating that "more than a simple linguistic nuance, the notion that social workers do not empower others, but instead, help people empower themselves is an ontological distinction that frames the reality experienced by both workers and clients" (p.32).

Weick, Rapp, Sullivan, and Kisthardt (1989) argue that although the importance of recognizing individual strengths is not new to the field of social work, there continues to remain "a subtle and elusive focus on individual or environmental deficit and personal or social problems"(p.350). The author's point out that many workers in the helping professions are still emphasizing human failing as the focus of assessment and intervention and are blaming the individual or community, rather than socio-environmental factors, for the difficulties they encounter. Blaming people for their problems ignores the larger social variables, such as race, income, and gender, which contribute to the difficulties people encounter and affect clients and the systems they exist in and in which they are a part. Much of the assessment, evaluation and intervention processes in social work stem from the identification of "the problem". One of the many troubles with problem based assessment and intervention is that it leaves the client seldomly successful and requires on-going intervention because the social worker is often

presumed to hold all the knowledge and authority over the client's life. Weick et al. (1989) state that "the difficulty or problem is seen as the linchpin for assessment and action"(p.351).

Deconstructing the discourse of risk

Deficit focused work forces us to look at the potential risk an individual has to fail, rather than the potential they have to succeed. In the book, Children and Families "At Promise": Deconstructing the Discourse of Risk, authors Swadner and Lubeck (1995) advocate replacing the language of children and families "at-risk" with the term "at promise". This movement beyond a focus of risk to one of health and adaptation sees people as experts of their own lives, not as problems. Swadener and Lubeck (1995) argue that "the rhetoric of risk is related to the persistent social stratification of in U.S. society ... to label persons' based on their race, first language, class, family structure, geographic location and gender as "at-risk" for failure"(p.2). The authors agree that the construction of an "at-risk" language serves to maintain a segregated and stratified society. It puts the blame of problems on the individual, family, or community, rather than exploring the politics and priorities of resource distribution.

In Bonnie Bernard's (Spring, 1997) interview with Steve Wolins, he challenges all helping professionals to shift their paradigms from the "damage" to the "challenge" model. He states that not only in society but also in professional academics, there is a damage orientation. "We have so few resources from the community to give us strength. It's very hard, to feel filled up, very hard to feel like you have a lot to give."(p.20). Wolin admits that one has to be aware that people come in pain and hurt and that focus on the damage part of their story has to be balanced with a strength based focus in order to validate their pain and their story and then to begin healing. Saleeby (1996) states that "having assessed the damage, social workers need to ensure that the diagnosis does not become a cornerstone of identity" (p.303) Risk seems to be

equated with damage in much of the literature which focuses on children "at risk". Wolin and Saleeby advocate for social work and therapy that recognizes the client's history, but focuses on the strength and ability to adapt which brought the client to where they are now.

The problem with an "at-risk" or problem focus

Authors Weick, Rapp, Sullivan, and Kisthardt (1989) state that "problem based assessments encourage individualistic rather than social-environmental explanations of human problems"(p.351). Often, more attention and focus is put on the problems of the individual and less on the environment that creates the problem, the larger social variables. Viewing people from a pathological perspective and using problem terminology "suggests that problems belong to or inhere in people and, in some way, express an important fact about who they are"(p.351).

Bonnie Bernard (Winter, 1996) stated that resiliency research provides a powerful rationale for moving our narrow focus from a risk, deficit, pathology focus to one that examines the strengths of youth and families to heal themselves and their situation. The acknowledgement that everyone possesses strengths and the capacity for change, Bernard says, "mandates that we move beyond our obsession with risk identification ... that has harmfully labeled and stigmatized youth, their families, and their communities as at-risk or high risk, a practice that perpetuates stereotyping and racism"(Bernard, 1996, p.9).

Bernard (1994) explains that thought is a vehicle through which we can either access the wisdom and resiliency within us or which we can access our conditioned thinking. This conditioned thinking is constructed through the messages and expectations of our past that we have internalized from the environments and people we live in and around. Often, people living in "at-risk" environments are sent messages that they are not good enough and are not valuable. These messages are internalized and become the conditioned thinking which leads people to

believe that they are powerless victims and they then begin to hold low expectations for themselves and others. Bernard (Winter, 1996) asserts that high expectation messages used in a strengths-based model of intervention should not only communicate firm guidance, structure and challenge but also convey a belief in a person's resilience, strengths and assets rather than problems and deficits.

In Bonnie Bernard's (Fall, 1997) interview with Dennis Saleeby, he explains that people who have defined themselves or who have been defined as victims throughout their lives often lose hope and motivation because they and those around them have low expectations for themselves. The word victim "becomes, in some ways, designations, imagery, symbols that people carry in their heads; it becomes part of their identity"(p.6). When conveying high expectation messages to someone, it expresses the belief that they have within themselves the knowledge, capacity, skills, personal traits and resources to move themselves in a different direction.

A strengths-based approach encourages client's development of traits commonly found in resilient survivors of at-risk situations and environments. Some of these traits include social competence, problem-solving skills, autonomy, and a sense of purpose and belief in a bright future. Dennis Saleeby quotes N. Garmenzy (1994) in his definition of resiliency as "the skills, abilities, knowledge, and insight that accumulate over time as people struggle to surmount adversity and meet challenges. It is an ongoing and developing fund of energy, and skill that can be used in current struggles"(p.298). Saleeby adds to this definition of resiliency that "resilience is not a trait or static dimension. It is the continuing articulation of capacities and knowledge derived through the interplay of risks and protections in the world" (p.299). A strengths-based approach highlights and builds on the capacities and knowledge the client already possesses in

the hopes of promoting resiliency to past, present and future challenging or threatening circumstances.

Using a strengths-based model to promote resiliency

Authors Weick, Rapp, Sullivan, and Kisthardt (1989) introduce the strengths perspective as "an alternative to a preoccupation with negative aspects of peoples and society and a more apt expression of some of the deepest values of social work"(p.350). Saleeby states that U.S. culture and helping professions are saturated with psychosocial approaches based on individual, family, and community pathology, deficits, problems, abnormality, victimization and disorder"(p.296). Using a strengths-based model means highlighting or uncovering the "untapped reservoirs" of skills, talents, and abilities that all people possess. Bernard (1994) argues that everyone is born with the potential for social competence, autonomy, problem solving and optimism. It is the goal of those working with a strengths perspective to identify and develop this potential. Weick et al. (1989) state that "those who hold a strengths perspective assume that this inner wisdom can be brought into more conscious use by helping people recognize this capacity and the positive power it can have in their lives"(p.353).

Social workers working from a strengths perspective believe that even the best trained professionals cannot judge how an individual should best live their life. Those working with a strengths perspective believe that every client proceeds through life in the best way they can. It is the task of the social worker to draw out and help the client improve upon the abilities and talents they already possess in order to improve their situation. When a client is able to recognize that they have power, expert knowledge and authority over their lives and the struggles they encounter, they take away an enduring and sustainable ability to grow and reshape the direction of their life. The assessment of client's strengths is also important to social work practice because

as McQuaide and Ehrenreich (1997) state, "from the perspective of the client, being able to access one's strengths effectively contributes not only to solving an immediate problem, but may also augment the client's ability to deal with future problems. From the perspective of the worker, understanding the resources a client brings to a situation is essential to treatment planning" (p.202).

The strengths-based approach in many ways reinforces the three broad categories which Bernard (Winter, 1996) believes foster resiliency: caring relationships, high expectation messages, and opportunities for meaningful contribution and participation. One aspect of a caring relationship is recognizing that people themselves are the best judges of knowing and doing what is best in their lives. Instead of telling people how to live their lives and making decisions for them, a strengths based approach asks, "What are the strengths and abilities of this individual, family, or community that will help them grow and change?" Weick et al. (1989) state that "continuing growth occurs through the recognition and development of strengths"(p.353).

Focusing on the strengths of people's mental, physical, emotional, social, and spiritual abilities also conveys high expectation messages and validates their ability to grow and change. Bernard (Winter, 1996) explains that when people accept the messages of oppression that society communicates to them, that they cannot change or grow as an individual, they begin seeing themselves as victims "through a negative filter of blame and low expectations"(p.2). A focus on people's strengths, rather than deficits and weakness, conveys a message of high expectation and will encourage growth toward healing.

Wolin (Spring, 1997) stated that in a deficit-oriented society, it's difficult for people to feel filled up and to feel like they have something to offer to society. This is often due to the lack in recognition of the inner wisdom and resources all individuals hold. In highlighting and

emphasizing these, people will more likely feel like they have talents and skills to offer the community. Saleeby (1996) explains that one of the goals of the strengths perspective in social work practice is to "reconnect people to the health in themselves and then direct them in ways to bring forth the health in others"(p.301). Many people who have lived in sickness, trauma, oppression, or abuse may find it difficult to recognize the strengths they already posses because they have been beaten down and out down so often in their lives. Social workers who are not familiar with a strengths perspective and who are accustomed to practicing from a problem-focused model may not expect to find many strengths from individuals coming from these types of situations. But, as Saleeby (1996) states, "what people learn about themselves and others as they struggle to surmount difficulty can become knowledge useful in getting on with one's life ... People learn from their trials and tribulations" (p.299). Using a strengths-based model transforms the client/worker relationship from one in which the worker holds all the authority and knowledge over the client's situation to one of appreciation and collaboration with clients. The basic tenets of the strengths perspective offer the client and worker the opportunity to "construct possibility and to reach out for promise.... and is an expression of some of the deepest values in social work" (Saleeby, p. 302)

Practice guidelines that foster a strengths perspective

Cowger (1994) lists 12 practice guidelines that foster a strengths perspective. The 12 practice guidelines include: give preeminence to the clients understanding of the facts, believe the client, discover what the client wants, make assessment of strengths multidimensional, use the assessment to discover uniqueness, use language the client can understand, make assessment a joint activity between and client, reach a mutual agreement on the assessment, avoid blame and blaming, avoid cause-and-effect thinking, and assess; do not diagnose.

Giving preeminence to the client's understanding of the facts means that the client's feelings and emotions, view and meaning of the situation should be the main focus of understanding the situation. Understanding that comes from what the practitioner believes or has learned through different theories should only be used to point out client strengths or recognize obstacles to client's objectives.

Believing the client means just that. In order to have a respectful relationship with a client, the practitioner needs to understand that the client's understanding of reality is just as valid as the practitioners comprehension of reality. Discovering what the client wants means having client's answer two questions, "What does the client want and expect from service?" and "What does the client want to have happen in relation to their current situation?". Client's are more likely to be motivated to meet and work toward goals if the goals are their own.

Moving the assessment toward personal and environmental strengths assists the practitioner to not get stuck or dwell in the barriers, but to find solutions in the strengths of the client. Making assessments of the client's multidimensional strengths means examining the client's internal strengths such as personal talents and skills, as well as examining the external strengths the client can draw on from the many different systems the client is a part of. In order to understand the client situation as unique, we also need to value them and view them as an individual. Otherwise, practitioners run the risk of treating clients as paper cut outs of each other, with emphasis on what the practitioner, rather than the client, believes is best. Using language the client can understand is respectful and also guarantees that the client is aware of what is being assessed and communicated.

Reaching mutual agreement and client and practitioner jointly making the assessment minimizes the power imbalance that typically exists in a client/practitioner relationship. This will

also help to ensure that the client is aware of the structure and direction of the process. By avoiding blaming the client for problem situations, the practitioner decreases the chance that the client will become defensive or lose motivation. When the practitioner relies on cause and effect thinking or diagnosis, they lose sight of the individual with whom they are working. Clients are not being helped when they are labeled or put into a certain category. When clients are encouraged to use their personal empowerment, individuality, and unique strengths and skills to overcome problem situations, they increase their strength and power as well as strengthen the community around them.

Chapter Three

Methodology

Overview

Chapter three contains eight sections, the important concepts and units of analysis, research design, sampling criteria and recruitment, data collection, data analysis, validity and credibility, human subject protection and limitations of the study.

Important concepts/ units of analysis.

According to the Kid's Capacity Initiative Assessment Subcommittee Report, resiliency can be enhanced for children if attention is given to certain individual attributes of the child and family and community supports are strengthened. Through the literature review and research conducted by the KCI committee, they found that the BERS and PHSCS and interviewing questions include the most crucial individual attributes, family resources, and community supports ... shown to be positively related to promoting resiliency in children. Epstein and Sharma (1998) state that "strength based assessment is defined as the measurement of those emotional and behavioral skills, competencies and characteristics that create a sense of personal accomplishment; contribute to satisfying relationships with family members, peers, and adults; enhance one's ability to deal with adversity and stress; and promote one's personal, social and academic development" (p.3).

Research Design

My research design is a single-system design. Single system designs are self-evaluations of one's own practice. I collected longitudinal measurements of a client system before, during and after implementing a strength-based intervention. Measurements included the Piers-Harris

Self-Concept Scale (PHSCS) and the Behavioral and Emotional Rating Scale, and eight open-ended questions (last page of BERS) with the foster parent. My major research question will be, "Based on the results of the test scores of the BERS and the PHSCS, was my strengths based intervention with my clients effective as part of my internship responsibilities?"

Data Analysis

I have been meeting with three children in foster care individually and with their foster parents at least three times a month. With the children, I also conduct quarterly review meetings to review the past three months in foster care and the progress of the childrens' goals and objectives they have set for themselves. Collaboratively with the foster children, I have been identifying their goals and objectives and specifying targets for intervention by asking, "What do we want to change with the strengths and resources the child has to work with?" with a specific focus on the variables measured by the BERS, PHSCS, and eight open-ended questions. I will construct and implement a strength-based intervention by having the children create their own goals and objectives every quarter and plan their own case conferences and whom they want to invite.

The effectiveness of the intervention will be measured by monitoring the interventive process over regulated units of time (repeat tests and interviews two times (once every three months), after baseline has been constructed. The evaluation design will be comparing the before, during, and after result outcomes of the BERS, PHSCS and the eight open-ended questions answered by the foster parents on the BERS by entering the baseline and intervention numerical results in the direct practice evaluation program called SINWIN to see if significant changes were found in targeted areas between interventions.

Sample – Sampling criteria and recruitment

All three boys in my study were in treatment foster care. Their ages were 8-11, one Caucasian and two African-American. All three boys had been in foster care for at least one year and had been living in the same foster home during that time.

I obtained my sample population from the six clients I was given to work with this year during my internship at Family Alternatives. I chose subjects between the ages of 8-12. Three of the clients I was given to work with fell within that age range and became the subjects of my study. For the purposes of this study, I collected data from a variety of sources: case files, school files, Behavioral and Emotional Rating Scale (BERS), Piers-Harris Self-Concept Scale (PHSCS), foster parent interview questions, home visits and quarterly reviews with the foster family.

The location of the study was held primarily in the foster family home. If privacy was needed and could not be found in the home, there were private meeting rooms available at the Family Alternatives office.

Data collection

The Piers-Harris Self Concept Scale is a brief, self-report measurement designed to help in the assessment of self-concept in children and adolescents. Self-concept, as assessed by the PHSCS, is defined as a relatively stable set of self-attitudes reflecting both a description and an evaluation of one's own behavior and attributes. The PHSCS focuses on the childrens' conscious self-perceptions, rather than attempting to infer about how they feel about themselves from their behaviors or the attributions of others. The Piers-Harris Self-Concept Scale provides six cluster scales: Behavior, Intellectual and School Status, Physical Appearance and Attributes, Anxiety, Popularity, and Happiness and Satisfaction. All cluster scales are scored in the direction of

positive self-concept so that a high score on a particular cluster scale indicates a high level of assessed self-concept within that specific dimension.

The Behavioral Emotional Rating Scale (BERS) is a standardized, norm referenced scale designed to assess the behavioral and emotional strengths of a child. The BERS is focused on what the child does well. The scale includes five subscales: Interpersonal Strengths, Family Involvement, Intrapersonal Strengths, School Functioning, and Affective Strength. All five subscales are scored in the positive direction. Interpersonal strength measures a child's ability to control his or her emotions or behaviors in social situations. Family involvement measures a child's participation in and relationship with his or her family. Intrapersonal strength measures in a broad sense a child's outlook on his or her competence and accomplishments. School functioning focuses on the child's competence in school and classroom tasks. Affective strength assesses a child's ability to accept affection from others and express feelings toward others. The foster children were asked to complete the Piers-Harris Self-Concept Scale. I administered the PHSCS to the children three times, once every three months. For the boys who could not read, I read it to them. Otherwise, I sat with them while they filled out the scale. The foster parent was asked to complete the Behavioral and Emotional Rating Scale (BERS) and was asked the eight open-ended questions from the BERS scale. I gave the foster parent the scale and have them send back to me three times, once every three months. The children and foster parents filled out the scales at approximately the same time. The BERS and PHSCS are standardized tests, which have been pre-tested.

Measurement issues – Validity and Reliability

There are some measurement issues to consider when conducting a single system design. Systematic measurement errors could include social desirability, acquiescent response set, and

cultural bias. The BERS and PHSCS are standardized scales with established high levels of empirically supported, reliability and validity. Although these scales have not shown serious validity and reliability problems due to the social desirability bias and acquiescent response set in large scale assessment studies, there are greater reliability and validity concerns when conducting a single-system design. Rubin and Babbie (1997) list some of these concerns: respondents are not anonymous, respondents may be sensitive to the impression they convey, with each repeated completion of instruments, respondent's answers may become less valid due to carelessness or because they remember their previous answers, respondents may be aware of the difference between treatment and non-treatment; they may know that if the service is being effective, their scores should go up. This may predispose them to convey a more positive impression when filling out the scales.

To reduce the concern of the acquiescent response set and social desirability bias, it was important to have at least one other observer, beside myself, of the study's results and findings. I also waited until termination to ask foster parents and children if the information obtained through my interventions and work with them can be used in the thesis project.

The language of the measurement instruments may be culturally biased. Rubin and Babbie (1997) recommend ways to try to avoid cultural bias and insensitivity in one's research. Some of the recommendations are to use in-depth pre-testing to correct problematic language and flaws in translation, avoid an unwarranted focus on the deficits of minorities, and in analyzing data, look for ways the findings may differ among different categories of ethnicity. The levels of measurement used in evaluating the effectiveness of using a strengths-based approach with three, one client systems will be an ordinal measurement used in the BERS scale and the interviewing questions and a nominal measurement used in the PHSCS.

Limitations of the Research Design

The limitations of the research design and methodology include the generalizability of the research findings, which is limited by the non-probability sampling and sample size. The three boys evaluated in the study may not be representative of all children living in foster care. A larger sample would have been better, but was not possible due to time constraints. The stable baseline found when evaluating the children's self-concept for the first time could have been the result of the Hawthorne Effect. During the early stages of intervention, the children could have shown elevated scores in the Piers-Harris Self-Concept Scale due to the initial excitement of having the attention of a student intern. The young age of the boys evaluated may have also effected the results. Because I had to read the questions of the PHSCS to some of the boys and because I usually had to bribe the boys with rewards to complete the scale, the risk of acquiescent response is high.

Chapter Four

Findings

Overview

Chapter four contains the finding of the study which include three tables describing the increase / decrease in scores of child self concept and foster parent concept of the child's success from a baseline score to Time 1 and Time 2. Additional data gathered was the responses from the BERS eight open ended questions, which the foster parents answered regarding each child.

Introduction

The three children studied in this direct practice evaluation are children who were placed in foster homes licensed through Family Alternatives. Family Alternatives is a treatment foster care agency, which licenses treatment foster families which have more training in working with children living in foster care, such as children's behavior and how to deal with issues of grief and loss, theoretical approaches to child development, and working with biological families. Recently, Family Alternatives developed a pilot program entitled "Kid's Capacity Initiative" (KCI), which is a strengths-based program that focuses in the evaluation, assessment, and programming of children on their strengths and positive attributes. This is a radical shift from the way most foster care agencies work, which focuses more on the problems and deficits of children and works toward "fixing" them.

The Piers-Harris Self-Concept Scale (PHSCS) and the Behavioral Emotional Rating Scale (BERS) are the two assessment tools that the KCI program uses to evaluate the strengths of each child and their increase or decrease in self-concept after entering the KCI program. The PHSCS is a self-scoring test taken by the children, which measures their self-concept. The BERS

is a self-scoring test as well that the foster parent takes and measures the child's behavioral and emotional state in five different areas, i.e. affective strength, school functioning, interpersonal strength, family involvement, and intrapersonal strength.

In my study, the three children evaluated took the PHSCS at approximately the same time as the foster parents, who took the BERS. A baseline was collected from the BERS and PHSCS. These tests were then administered two more times approximately 3 months apart, which are reported in the findings as Time 1 and Time 2.

Study results

Using the SINWIN program for evaluating direct practice, after entering the baseline and intervention score in each cluster area of the BERS and PHSCS for every child, I found no significant changes in score between interventions: Time 1 and Time 2. This demonstrates that there was no significant change in the child's self concept or the foster parent's concept of how well the child was doing during the six-month evaluation period. I was looking for an increase or decrease in the baseline to Time 1 and Time 2 scores. An increase would signify a positive change in the child's self-concept in the PHSCS in each cluster area. An increase in the BERS scores would signify a positive increase in the foster parents' concept of how well the child was doing in each cluster area. A decrease in score from the baseline to Time 1 and Time 2 in the PHSCS and BERS would signify a negative change in the child's self concept and foster parents concept of how well the child is doing in each cluster area. Very slight increases or decreases were found when evaluating change in each cluster area of both the BERS and the PHSCS.
In evaluating the slight increases and decreases, two of the three children studied did show a slight general decrease in levels of self-concept. Also, in two of three children's reporting of their self-concept was counter to the reporting by their foster parents. This means that while the slight

general self-concept levels were decreasing in two of the three children's reports in the PHSCS, their foster parents were reporting a slight general increase in the children's behavioral and emotional state.

The following tables will show the findings for each child from the BERS and PHSCS.

Table 1. Child "DP"

Table 1. provides the baseline, Time 1 and Time 2 scores in the cluster areas for both the BERS and PHSCS for child "DP". An increase in score signifies positive change. A decrease in score signifies negative change.

BERS Cluster areas	Baseline	Time 1	Time 2
Interpersonal Strength	18	20	21
Family Involvement	15	18	19
Intrapersonal Strength	9	12	10
School Functioning	7	7	4
Affective Strength	11	11	12

PHSCS Cluster areas	Baseline	Time I	Time 2
Behavior	11	9	9
Intellectual & School Status	15	12	11
Physical Appearance & Attrib	7	8	5
Anxiety	8	8	8
Popularity	7	7	6
Happiness & Satisfaction	9	10	6

Results from the BERS for child "DP", an evaluation of foster child by foster parent, showed an increase in cluster areas Interpersonal Strength, Family Involvement, and Affective Strength, while the areas of School Functioning and Interpersonal Strength decreased.

Results from the PHSCS for child "DP", an evaluation of the foster child by the foster child, found that in all areas but one, self-concept scores decreased. Anxiety scores stayed the same, while Behavior, Intellectual and School Status, Physical Appearance, Popularity, and Happiness and Satisfaction decreased.

CHILD DP

The results of baseline and intervention scores for Child DP can be found in Table 1. His self-assessment scores generally decreased from time of baseline to the second intervention. I can speculate on why his self-concept score decreased. Child DP has been in numerous foster homes since the age of two. Although he is currently in a relatively stable placement, his biological father continues to work on reunifying with his son and has regular bimonthly visits. Child DP has strongly identified with foster mother as his mother, and has difficulty when his father frequently suggests that they will soon be reunified. Child DP displays obvious signs of fear anxiety before and after visitation with his father. His father recently remarried a woman with a daughter who is close in age to child DP. Child DP has a very strained relationship with his new stepmother and stepsister, which made visitation with his father more stressful. There are eight children living in Child DP's foster home, and he is the only child who has not been adopted by the foster mother. This may make Child DP feel like he does not totally belong to either his father or his foster mother.

Child DP will be changing school in the fall and his current school has been trying to prepare him for the transition. The school reports that Child DP has been intentionally failing in many areas in order to stay in his current program. He has stated that he is not ready to leave his current school. Child DP's foster parent and teacher have both reported that he has very low social skills and behavioral difficulties which often annoy peers and prevent him from building relationships with others.

Child DP's foster mother reported in the BERS a general increase, in the areas of Interpersonal Strength, Family Involvement, and Affective Strength. I can speculate that the foster mother saw an increase in these areas for some reasons that she had reported to me during

our quarterly review meetings. When Child DP first moved to her home, he was very destructive of other's property, he was displaying self-harmful behavior and spoke of suicide often. He seemed anxious and worried at all times. These behaviors continue to decrease dramatically as Child DP stabilizes and feels more secure that he will not be moving to another home. During the time of the first intervention, Child DP was assigned a mentor who has taken him out on weekly activities and they joined the Boy Scouts together. The mentor has seemed to be a very positive influence on Child DP and Child DP has formed a strong attachment to him.

Results from BERS eight open ended questions

When answering the eight open-ended questions of the BERS, child DP's foster mother reported that the child's favorite activities included reading and playing outside. The foster mother did not report that the child had any favorite sports and his favorite subject was reading. The foster mother reported that the child's best friend was his sister. At the time of second intervention, it was reported that his best friend was his brother. Miss K remained his favorite teacher during baseline and interventions. The child's responsibilities in the home were taking care of the dog and keeping his room neat. At a time of need, the foster mom reported that the child would turn to her or his teacher for support. Child DP was described as having a great sense of humor and being very tenderhearted, and good with small children and animals.

Table 2. Child "RL"

Table 2. provides the baseline, Time 1 and Time 2 scores in the cluster areas for both the BERS and the PHSCS for child "RL". An increase in score signifies positive change. A decrease in score signifies negative change.

BERS Cluster areas	Baseline	Time I	Time 2
Interpersonal Strength	17	11	19
Family Involvement	15	18	11
Intrapersonal Strength	17	13	11
School Functioning	13	13	9
Affective Strength	12	10	5

PHSCS Cluster areas	Baseline	Time I	Time 2
Behavior	12	15	14
Intellectual & School Status	10	12	12
Physical Appearance & Attrib	10	9	11
Anxiety	4	5	7
Popularity	2	4	7
Happiness & Satisfaction	5	8	8

BERS results for child "RL" showed a decrease in all areas but one. Family Involvement, Intrapersonal Strength, School Functioning, and Affective Strength decreased while Interpersonal Strength increased.

Results from the PHSCS for child "RL" found an increase in all areas.

Child RL

Child RL's self-assessment scores generally increased from time of baseline through the first and second intervention. Some possible reasons for this may be that during this time, he was diagnosed with depression and has been taking Wellbutrin which he reports makes him feel better and more happy. His foster mother reports that he seems more talkative and active since being on the medication. He began participating in grief and loss support groups at school, after his biological mother's parental rights had been terminated which seemed to be helpful for him. He also had been working on a Life Book with his brother in therapy, which enabled him to talk about his feelings of loss and grow closer to his brother. The children in the foster home have begun including him in more activities, whereas before, Child RL would only observe and not participate.

Child RL's foster mother reported a general decrease in BERS scores in all cluster areas. This could be due to many factors. Child RL was probably the most emotionally attached child of his seven biological siblings to his biological mother. The termination of her parental rights and loss of contact with her seemed to affect him the most. Child RL would often cry at night and has difficulty verbalizing strong emotions, which made it more difficult for him to get the support he most likely needed. Child RL also has severe learning disabilities and difficulty relating to peers, which make going to school academically and socially difficult. He often shuts down when frustrated and has difficulty getting back on task. This caused him to spend a lot of time in school detention. During the time of the first intervention, a new foster child moved into the home that Child RL reports often antagonizes him and annoys him. The new foster child's behavior in many ways disrupted the relationships that Child RL had with the boys who were already in the home.

Results from BERS eight open ended questions

When answering the eight open-ended questions on the BERS, child RL's foster mother reported that the child's favorite activities included swimming, cooking, Play Station, biking, wrestling, fixing things, quietly playing with Legos, putting puzzles together, and rollerblading. His favorite sports included football, soccer, wrestling, and bike riding. His best subject remained math. She reported that he did not have a best friend. Child RL's favorite teacher remained Ms. R. His responsibilities within the home included cleaning room, taking out trash, mopping floors, and cleaning the cat box. In times of need, the foster parent reported that child RL would turn to her or his teacher. The best things about the child were described as his willingness to please people, his smile, helpfulness, and generosity.

Table 3. Child "DL"

Table 3. provides the baseline, Time 1 and Time 2 scores in the cluster areas for both the BERS and PHSCS for child "DL". An increase in score signifies positive change. A decrease in score signifies negative change.

BERS Cluster areas	Baseline	Time 1	Time 2
Interpersonal Strength	22	23	17
Family Involvement	13	20	14
Intrapersonal Strength	20	20	20
School Functioning	11	12	13
Affective Strength	12	12	10

PHSCS Cluster areas	Baseline	Time I	Time 2
Behavior	15	14	11
Intellectual & School Status	16	16	11
Physical Appearance & Attrib	12	11	8
Anxiety	11	4	4
Popularity	11	4	5
Happiness & Satisfaction	10	9	8

BERS results for child "DL" showed a decrease in cluster areas Interpersonal Strength, Family Involvement, Affective Strength. An increase was found in School Functioning and scores for Intrapersonal Strength stayed the same.

Results from the PHSCS for child "DL" showed a general decrease in all areas.

Child DL

Child DL's self-assessment scores showed a general decrease in all areas of the PHSCS. His foster mother also reported a general decrease in all areas, with the exception of School Functioning. I can speculate that some of the reasons for the general decrease could be that during the time of evaluation, Child DL lost permanent contact with his biological mother. Knowing that he was not returning to live with his mother and that he is not going to be adopted by his foster mother, he may be feeling very insecure about where he will live in the future. At the time the baseline was taken, Child DL was often doing very well in school both academically and behaviorally. Since his biological mother's parental rights were terminated, he has had trouble staying on task and following directions. In the foster home, he increasingly needs redirection and has been more aggressive toward the other boys in the home. He is also changing schools next year and has had difficulty adjusting to the idea of that transition. Academically, Child DL continues to be successful and seems to both his foster parent and his teachers to be a very bright and intelligent child.

Results from BERS eight open ended questions

The foster parent for child DL answered the eight open-ended questions of the BERS by stating that the child's favorite activities included reading books, putting puzzles together, playing with Legos, bike riding, swimming, and wrestling. His favorite sports included baseball, wrestling, basketball, football, and bike riding. She reported that his best friend was Dominique and he had many favorite teachers. His responsibilities within the home included cleaning room and taking out the trash, In a time of need, the child would turn to his foster parent or a teacher. Child DL's foster mother describes the best things about him as his willingness to please people, his beautiful eyes and smile, his confidence, and desire to learn new things.

Chapter Five

Discussion

Why didn't the BERS and PHSCS scores get better using the KCI model?

Initially, when I began this study, I speculated that the scores of the two assessment tools would show an increase in the child's self-concept and the foster parent's rating of the child's emotional and behavioral state. Although there were slight increases and decreases in the scores, no significant changes were found. I can speculate that this may have been due to a number of factors.

The first factor was the lack of time I had to work with and evaluate the three children in the study. Due to the time constraint of my internship, I had a limited time to work with these children. If I had more time to evaluate and work with the three children, the results may have been different.

Another factor, which may have affected the results of the assessment tools, was that the children only saw me twice a month. They also work with many other adults included in what Family Alternatives calls the child's treatment team, i.e. foster parent, therapist, county social worker, school teacher, etc. Everyone else on treatment team was not necessarily using a strength-based approach.

Typically, a treatment team is a group of professionals who work together to establish intervention strategies for the foster child based on finding solutions for them and fixing problems. The Kid's Capacity Initiative (KCI) model uses a "circle of support", rather than a "treatment team" in which the children help identify the support members who value and respect their abilities and needs, and who work with them supporting their growth and development.

The treatment team works to identify problems and treatments, which will promote progress. Outcomes are based on identifying causation and eliminating problems. The circle of support focuses on a child's needs, strengths and abilities. Outcomes are directed to positive identity, empowerment and community connections.

From a systems theory perspective, change cannot be made by only changing one facet or system that a person is involved with. All systems need to be looked at in order for real assessment and change to occur. In order to get accurate information on whether a strengths-based approach to working with children makes a positive change, more adults who are involved in the other systems that the child is involved with would also need to be working from a strengths perspective.

I also learned through this study that because the strengths perspective is neither a model nor a theory, people hold many different definitions of what it means to be working with a strengths perspective. During reflection on this study and the work I did with the three boys involved, I have realized that what I considered to be strengths-based work seemed to be a lot of surface work that dealt with many external rather than internal factors. I define external factors as those that can be recognized by appearance. For example, I found myself giving children a lot of praise for what seemed to be their most positive qualities and accomplishments but did not look for ways beyond that to capitalize on those strengths to work through challenges they may have been facing at that time. At times, I also found myself slipping back into pathologizing the children and viewing them as their labels they had been given, rather than working with them to recognize their challenges as only an obstacle to work around, rather than a part of their identity.

I have learned through this process that I will constantly need to be monitoring and reflecting on my own assumptions and views of myself and the people I work with, in order to maintain strengths-based work.

One other factor, which may have affected the results of the study, was the children did not always appear to be thoughtfully answering the PHSCS. Some times I would encourage the child to finish filling out the PHSCS with a reward. It seemed in some instances that the child would rush through the PHSCS in order to get the reward.

Why was there such a disparity between the kids reporting and the highly trained foster parents reporting?

In the current treatment foster care programs, foster parents attend trainings mostly focused on modifying behavior, assessing problems and pathology, and working as part of a treatment team. In the Kid's Capacity Initiative (KCI) program, education for foster parents is centered around a strengths based philosophy and orientation, with training on strength assessment tools, and strength and capacity building. In the current treatment foster care program, in which all foster parents in the study were trained, the focus is more on fixing problems and modifying behavior rather than on what kids might necessarily need to grow and develop positive identity and empowerment. This may be one of the reasons for the disparity between the child and foster parent reporting.

Another factor which may led to the disparity in reporting is that many of the training opportunities for foster parents in the current treatment program focus on managing behavior and assessing problems from the outside, rather than looking deeper into the child to and listen to them to find out what the feelings are behind the behavior. A child could look like they are doing and feeling okay from an outward appearance, but inside may be feeling differently.

Why is strengths-based reporting and child reporting important?

One of the reasons why strength-based reporting is important is that if the outcomes show that strength-based practice is having a positive effect on children and is enhancing resiliency, the research could make major impact on the Family Alternatives agency as well as the larger foster care field.

Child reporting is important because it is helpful for foster parents, workers, therapists, and all other supportive adults to identify where the child has progressed and where they still need support. In a strength-based report, the focus would be on the positive qualities and assets the child possesses and would promote and develop those qualities to encourage healthy and positive development.

Strength-based reporting such as the Behavioral Emotional Rating Scale (BERS) and Piers-Harris Self-Concept Scale (PHSCS) identify protective factors which the child possesses and foster those which helps the supportive adults in the child's life to cultivate those qualities, such as social competence, problem-solving, autonomy, and a sense of a bright future.

Strengths and limitations of study

The strengths of using a single-system design are that it will provide rapid feedback in implementing a strengths-based intervention, testing hypothesis of the client-situation, and evaluating whether or not my practice objectives have been achieved. The outcomes of the direct practice evaluation directly affect participants of the study. Thinking about evaluation during the course of my practice will help sharpen my thinking and encourage me to act effectively. I will be incorporating the client's values into the choice of targets and goal setting procedures. Single-system designs usually provide objective and systematic information for observing changes in the client's condition over time and focuses on the individual client rather than

reflecting average scores from large research designs. Single-system designs are flexible and capable of changing as the client's circumstance change and provide a model for demonstrating my accountability to clients, communities, and myself.

The limitations of a single-system design are that there will be greater concern for the chance of the acquiescent response set and the social desirability bias. This design will not be as effective in ruling out alternative explanations of results as a sophisticated classical design. Because of time limitations in working with the three clients (6 months), the evaluation will not be as accurate as it would if the length of direct practice with them were longer and on-going. Any conclusions I draw from the study will be suggestive rather than definitive and will not yield precise descriptive statements about a large population.

Another limitation of my thesis project was the assessment tools I used to evaluate the effectiveness of my practice, particularly the Piers Harris Self-Concept Scale. The PHSCS seemed to subjectively determine positive self-concept statements, which the child was to either agree or disagree with regarding themselves. For example, there were statements such as "I am different from other people", "I am shy", "I cry easily", and I am a leader in games and sports", which could be seen as either positive or negative qualities, depending on who is evaluating the scale. McQuaide and Ehrenreich (1997) state that strength is not a culture free concept. "Ethnicity, race, social class and gender affect strength in various ways. Cultures value emotional control and emotional expressiveness differently and expect prescribed emotional responses-10 particular situations" (204). Coping styles also vary across race, class, and gender differences. The Piers Harris Self-Concept Scale seems to be dominated by Western, Caucasian values and beliefs. For example, it sees independence, individuality, emotional control, and leadership as strengths. There is need for a more culturally sensitive assessment tool to measure strengths.

Implications for practice and the field of social work

The implications of conducting a single-system design intended to evaluate the effectiveness of using a strengths-based approach with children in treatment foster care for practice are to make more effective and humane decisions about promoting the desired objectives of foster parents and children in treatment foster care. As Charles Cowger (1994) states, "review of the social work literature on human behavior and the social environment reveals that it provides little theoretical or empirical content on strengths ... The assessment literature, including available assessment instruments, is overwhelming concerning with individual inadequacies" (262). Instead of taking a behavioral baseline of clients deficits, identifying their strengths and building on those throughout the therapeutic process will put the focus of therapy on what the client can do to better their situation rather than what they cannot do. This type of assessment reinforces client competencies, stimulates hope, mobilizes people and liberates them from diagnostic labeling. I will also be gaining skills in learning how to evaluate my own practice and how to integrate research and practice.

This study has also helped me to realize that there is a need for a strengths-based theory, and through the theory, a model to be developed. Currently, the strengths perspective is made up of many different people's ideas on what strengths-based work is. With a strengths-based model, it would be easier to study the effectiveness of a strengths-based approach because there would be guidelines to follow and similar studies could be compared. At this time, people working from a strengths perspective could be doing very different work with clients because there is no model from which to base one's work.

Implications for the field of social work when conducting a single-system design are that they advance the empirical base of social work practice by adding to research practice on the

importance of direct practice evaluations and my single-system design will advance the scientific basis of strength-based interventions.

If it is found that focusing on children's strengths rather than focusing on solving children's problems proves to be more effective in strengthening their problem-solving skills, building their skills to help them become productive, contributing members of their community, and eases the child's transitions between home and out of home placement, it has the potential to spread change throughout the entire child welfare system. It could possibly change government policies at the county, state, and national level to facilitate a more strengths-based approach to working with children and families.

References

Ashford, J.B., Lecroy, CW., and Lortie, K.L. (1997). *Human Behavior in the Social Environment.* Brooks/ Cole Publishing Co.

Berg, I.K. and DeJong, P. (1996). Solution building conversations: Constructing a sense of competence with clients. *Families in Society: The Journal of Contemporary Human Services.* June 1996, pp. 376-391.

Bernard, Bonnie (1996). The foundations of the resiliency paradigm. *Resiliency in Action.* Winter 1996.

Bernard, Bonnie (1994). The Health Realization approach to resiliency. *Western Center News.* December 1994, vol. 8, no. I

Bernard, Bonnie (1997). Putting the strength-based approach into practice: An interview with Dennis Saleeby, DSW. *Resiliency in Action.* Fall 1997.

Bernard, Bonnie (1997). Focusing therapy on what families do right: An interview with Steve Wolin, MD. *Resiliency in Action.* Spring 1997.

Cowger, C.D. (1994). Assessing Client Strengths: Clinical Assessment for Client Empowerment. *Social* Work,139 (3), 262-268.

Epstein, M.H., and Sharma, J.M. (1998). *Behavioral and Emotional Rating Scale: A Strengths Based Approach to Assessment. Examiners Manual.* Austin, Texas: Pro-Ed.

Masten, A.S., Best, K.M. and Garmezy, N. (1990). Resilience and development: Contributions from the study of children who overcome adversity. *Development and Psychopathology.* 2(1990), 425-444.

McQuaide, S. and Ehrenreich, J. H. (1997). Assessing client's strengths. *Families in Society,* March/ April, p. 201-212.

Nichols, M.P., and Schwartz, R.C. (1998). *Family Therapy: Concepts and Methods (fourth ed.).* Needham Heights, MA.: Allyn and Bacon.

Payne, Malcolm (1997). *Modern Social Work Theory, (second edition).* Chicago, IL: Lyceum Books.

Saleeby, Dennis (1992). *The Strengths Perspective in Social Work: Power in the People.* White Plains, NY: Longman.

Saleeby, Dennis (1997). *The Strengths Perspective in Social Work. Power in the People (second edition).* White Plains, NY: Longman.

Saleeby, Dennis (1996). The strengths perspective in social work practice: Extensions and cautions. *Social Work,* vol.41, no.3.

Simon, B.L. (1990). Rethinking empowerment. *Journal of Progressive Human Services, l(l), 27-40.*

Smith, Carolyn and Carlson, B.E. (1997). Stress, coping, and resilience in children and youth. *Social Service Review,* June *1997, p.231-256.*

Swadener, B.B. and Lubeck, S. editors (1995). *Children* and *Families "At Promise": Deconstructing the Discourse of Risk. Albany:* State University of New York Press.

Weick, A., Rapp, C., Sullivan, W.P., and Kisthardt, W. (1989). The strengths perspective for social work practice. *Social Work*, June 1989, p.350-354.

Weick, A. (1992). "Building a Strengths Perspective for Social Work." In Dennis Saleeby (Ed.), *The Strengths Perspective in Social Work Practice: Power in the People*. White Plains, NY: Longman.

Appendix A.
Eight open-ended questions from BERS

1. What are the child's favorite hobbies or activities? What does the child like to do?
2. What is the child's favorite sport(s)?
3. In what school subject(s) does the child do best?
4. Who is this child's best friend(s)?
5. Who is the child's favorite teacher(s)?
6. What job(s) or responsibilities has this child held in the community or in the home?
7. At a time of need, to whom (e.g., parent, teacher, friend, relative) would this child turn for support?
8. Describe the best things about this child.
9. What activities/ programs does the child participate in within their school, neighborhood, or church?
10. At a time of need, to whom in the family would the child turn for support?
11. What are the expectations, rules, and consequences for the child while living with you?

Appendix B.
Statements included in BERS five subscales.

Interpersonal Strength
Uses anger management skills
Expresses remorse for behavior that hurts or upset others
Reacts to disappointments in a calm manner
Considers consequences of own behavior
Accepts criticism
Accepts responsibility for own actions
Loses a game gracefully
Listens to others
Admits mistakes
Accepts "no" for an answer
Respects the rights of others
Shares with others
Apologizes to others when wrong
Is kind toward others
Uses appropriate language

Family Involvement
Demonstrates a sense of belonging to family
Trusts a significant person with his or her life
Participates in community activities
Maintains positive family relationships
Communicates with parents about behavior at home
Interacts positively with parents
Participates in church activities
Interacts positively with siblings
Participates in family activities
Complies with rules at home

Intrapersonal Strength
Is self-confident
Demonstrates a sense of humor
Demonstrates age-appropriate hygiene skills
Requests support from peers and friends
Enjoys a hobby
Identifies own feelings
Identifies personal strengths
Is popular with peers
Smiles often
Is enthusiastic about life
Talks about the positive aspects of life

School Functioning
Completes a task on first request
Completes school tasks on time

Appendix B (continued)

Completes homework regularly
Pays attention in class
Computes math problems at or above grade level
Reads at or above grade level
Studies for tests
Attends school regularly
Uses note taking and listening skills in school

Affective Strength
Accepts a hug
Acknowledges painful feelings
Asks for help
Shows concern for the feelings of others
Discusses problems with others
Accepts the closeness and intimacy of others
Expresses affection for others

Appendix C.
Statements included in PHSCS six cluster groups

Behavior
I am well behaved in school.
I do many bad things.
I often get into trouble.
I get into a lot of fights.
I am good in my schoolwork.
I hate school.
I am a good person.
I am often mean to other people.
I behave badly at home.
I think bad thoughts.
It is usually my fault when something goes wrong.
I cause trouble to my family.
My family is disappointed in me.
I am obedient at home.
My parents expect too much of me.
I am picked on at home.

Intellectual and School Status
I can give a good report in front of the class.
I am an important member of my class.
My classmates in school think I have good ideas.
I often volunteer in school.
My friends like my ideas.
I have good ideas.
I am smart.
I am good in my schoolwork.
When I grow up, I will be an important person.
I am an important member of my family.
In school, I am a dreamer.
I am a good reader.
I am slow in finishing my schoolwork.
I get nervous when the teacher calls on me.
I forget what I learn.
I am dumb about most things.
I am well behaved in school.

Physical Appearance and Attributes

My looks bother me.
I am good-looking.
I have nice hair.
I have a good figure.
I have a pleasant face.
I have pretty eyes.

Appendix C (continued)

My classmates in school think I have good ideas.
I am a leader in games and sports.
My friends like my ideas.
I am popular with boys.
I am smart.
I am popular with girls.
I am strong.

Anxiety
I am nervous.
I worry a lot.
I get worried when we have tests in school,
I am often afraid.
I am shy.
I cry easily.
I am often sad.
I feel left out of things.
I wish I were different.
I give up easily.
I get nervous when the teacher calls on me.
I like being the way I am.
My looks bother me.
I am unhappy.

Popularity
People pick on me.
My classmates make fun of me
I have many friends.
It is hard for me to make friends.
I am among the last to be chosen for games.
I am unpopular.
I feel left out of things.
I am popular with girls.
My classmates in school think I have good ideas.
I am shy.
In games and sports, I watch instead of play.
I am different from other people.

Happiness and Satisfaction

My looks bother me.
I like being the way I am.
I have a pleasant face.
I wish I were different.
I am unhappy.
I am a happy person.
I am cheerful.

Appendix C (continued)

I am lucky.
I am easy to get along with.
I am a good person.